STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

C. DWIGHT GROVES, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 00-2285

RECOMMENDED ORDER

A hearing was held pursuant to notice, on October 3, 2000, in Lake City, Florida, by Barbara J. Staros, assigned Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Gerald D. Mills, MBA, JD
Healthcare Consultants of America, Inc.
Post Office Box 52979
Atlanta, Georgia 30355

For Respondent: L. William Porter, II, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308-5403

STATEMENT OF THE ISSUE

Whether Petitioner is liable for overpayment of Medicaid claims for the period of January 1, 1997, through December 31, 1998, as stated in Respondent's Final Agency Audit dated March 10, 2000.

PRELIMINARY STATEMENT

By Final Agency Audit Report dated March 10, 2000, the Agency for Health Care Administration (Respondent) notified C. Dwight Groves, M.D. (Petitioner) that he was liable for overpayment of Medicaid claims in the amount of $55,829.04, for the period from January 1, 1997, through December 31, 1998. Petitioner disputed being liable for reimbursement to Respondent for overpayment of the Medicaid claims and requested a hearing. On May 30, 2000, this matter was referred to the Division of Administrative Hearings.

At hearing, Gerald D. Mills, MBA, JD, was authorized to appear on behalf of Petitioner as a Qualified Representative pursuant to Rule 28-106.106, Florida Administrative Code.

The parties announced at the beginning of the hearing that they had resolved all but one issue raised in the agency's audit and that the resulting amount of overpayment in dispute was approximately $51,000. The parties stipulated that the remaining issue to be litigated was whether the services billed by an advanced registered nurse practitioner (ARNP) should be subject to reimbursement by Petitioner to Respondent.

Petitioner was not present at the hearing. Petitioner presented no witness testimony and entered three exhibits numbered 1, 3, and 5 into evidence and offered four exhibits which were rejected. Respondent presented the testimony of two

witnesses and entered 6 exhibits (Respondent's exhibits numbered 1-24 (composite), 27, 36, 37, 38 and 39.)[1]

At the request of the parties, the time for filing post-hearing submissions was set for more than ten days following the filing of the transcript. The parties, therefore, waived the provisions of Rule 28-106.216, Florida Administrative Code. The transcript, consisting of one volume, was filed on October 26, 2000. The parties timely filed post-hearing submissions which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times material hereto, the Agency for Health Care Administration (Respondent) was the state agency charged with administration of the Medicaid program in the State of Florida pursuant to Section 409.907, Florida Statutes (1997).

2. At all times material hereto, C. Dwight Groves, M.D. (Petitioner) was a licensed medical doctor in the State of Florida and was providing medical services to Medicaid recipients. Petitioner provided the medical services pursuant to a contract with Respondent. When first accepted as a Medicaid provider in June of 1995, Petitioner was assigned provider number 3777278-00 and was approved for providing and billing for physician services. The letter notifying Respondent that he was accepted as a Medicaid provider referenced an enclosed handbook which explained how the Medicaid program operates and how to bill

Medicaid. At that time Petitioner practiced in Key West, Florida.

3. In October of 1997, Petitioner notified Respondent of a change of address to Southern Group for Women in Lake City, Florida. According to the answers provided to a Medicaid Provider Questionnaire, Petitioner became affiliated with Southern Group for Women on October 16, 1997. Petitioner's medical practice was and is in the area of obstetrics and gynecology.

4. Respondent's witness, Toni Steele, is employed by Respondent in its Medicaid program integrity division. During the audit period in question, she was a senior human services program specialist. Her job responsibility was to ensure that Medicaid providers in Florida adhered to Medicaid policy and rules.

5. Medicaid program integrity uses several detection devices to audit Medicaid provider billing. One such device is what is referred to as a "one and a half report." This type of report will indicate when a provider "spikes" one and a half times his or her normal billings. During December of 1998, Ms. Steele noticed a "spike" in Petitioner's billings. Because of this spike, Medicaid program integrity, ordered an ad hoc sampling of his billings within a two-year billing period, January 1, 1997, through December 31, 1998. She reviewed the sample and, using the Medicaid Management Information System, was

able to look at the actual dates of service and view the procedure code that was billed and paid by Medicaid.

6. Ms. Steele then conducted an on-site visit to Petitioner's office. As is her usual practice, she took a tour of Petitioner's office looking at what types of lab equipment were there, the State of Florida license, and the number of medical personnel employed.

7. During the on-site visit, Ms. Steele presented the office manager with a computer-generated list of patients and requested that the office manager provide the medical records of those patients on the list. The requested 31 files were provided to her within the requested time frame.

8. Ms. Steele reviewed the patients' files received from Petitioner's office for the purpose of determining policy violations according to the Medicaid Physician Coverage and Limitations Handbook (Nov. 1997), the Advanced Registered Nurse Practitioner Coverage and Limitations Handbook (Nov. 1997), and the Medicaid Provider Reimbursement Handbook (Nov. 1996).

9. The Medicaid Provider Reimbursement Handbook (Nov. 1996) provides in pertinent part:

> Introduction:
>
> Every facility, individual and group practice must submit an application and sign an agreement in order to provide Medicaid services.

> Note: See the Coverage and Limitations Handbook for specific enrollment requirements.
>
> Group Enrollment:
>
> When two or more Medicaid providers form a group practice, a group enrollment application must be filed with the Medicaid fiscal agent.
>
> * * *
>
> Renewal:
>
> A provider agreement is valid for the time period stated in the agreement and must be renewed by the provider by completing a new provider agreement and submitting it to the Medicaid fiscal agent 30 days prior to the expiration date of the existing agreement.

10. The Physician Coverage and Limitations Handbook (Nov. 1997) provides in pertinent part:

> Other Licensed Health Care Practitioners:
>
> If a physician provider employs or contracts with a non-physician health care practitioner who can enroll as a Medicaid provider and that health care provider is treating Medicaid recipients, he or she must enroll as a Medicaid provider.
>
> Examples of non-physician health care practitioners who can enroll as Medicaid providers include but are not limited to: physician assistants, advanced registered nurse practitioners, registered nurse first assistants, physician therapists, etc.
>
> If the services rendered by a non-physician health care practitioner are billed with that practitioner as the treating provider, the services must be provided in accordance with the policies and limitations contained in that practitioner's program-specific Coverage and Limitations Handbook.

* * *

> Physician Supervision:
>
> Delivery of all services must be done by or under the personal supervision of the physician.
>
> Personal supervision means the physician:
>
> . is in the building when the services are rendered, and
> . reviews, signs and dates the medical record within 24 hours of providing the service.

11. The Advanced Registered Nurse Practitioner Coverage and Limitations Handbook (November 1997) provides in pertinent part:

> ARNP in a Physician Group:
>
> If an ARNP is employed by or contracts with a physician who can enroll as a Medicaid provider, the physician must enroll as a group provider and the ARNP must enroll as a treating provider within the group.
>
> If the services rendered by the ARNP are billed with the ARNP as the treating provider, the services must be provided in accordance with the policies and limitations contained in this handbook.

12. According to answers provided on a Medicaid Provider Questionnaire completed in February of 1999, Anna Hall Kelley, ARNP, became affiliated with Southern Group for Women on October 16, 1997. The answers provided on the Questionnaire indicated that Petitioner and Nurse Kelley formed a partnership and practiced together at Southern Group for Women. Nurse Kelley did not testify at the hearing.

13. In reviewing the requested medical records, Ms. Steele noted that some of the medical records were signed by Nurse Kelley, ARNP, indicating that Nurse Kelley, not Petitioner, performed the services. They were not countersigned by Petitioner.

14. Nurse Kelly was not an enrolled Medicaid provider at the time the services were rendered as her provider number expired on May 31, 1997. Nurse Kelley signed a new enrollment application to be a Medicaid provider in October of 1999. Thus, she was not an enrolled provider from June 1, 1997, through the remainder of the audit period.

15. Nurse Kelley saw patients and billed for those services under Petitioner's individual provider number. Neither Nurse Kelley nor Petitioner applied for a group Medicaid provider number during the audit period.

16. Respondent sent a Preliminary Agency Audit Report to Petitioner on September 21, 1999, notifying him of a preliminary determination of a Medicaid overpayment in the amount of $71,261.92.

17. Respondent sent a Final Agency Audit Report to Petitioner on March 10, 2000, notifying him that the Agency made a determination of a Medicaid overpayment in the amount of $55,829.04. Because of recalculations made by Respondent, the amount of reimbursement sought was reduced to $55,647.92. As a result of a stipulation of the parties prior to the hearing, the

amount of reimbursement was further reduced to approximately $51,000.

18. As to the statistical aspect of Respondent's audit, Respondent presented testimony of a statistical expert, Dr. Robert Peirce, who is employed by Respondent as an administrator in the Bureau of Program Integrity. Dr. Peirce's testimony is considered credible.

19. Dr. Peirce developed the statistical methodology used in the statistical sampling of Dr. Groves' medical files. Dr. Peirce studied the methodology used by Respondent in this case, and concluded that the statistical procedures used in the audit of Petitioner were in accordance with customary statistical methodology.

20. The statistical analysis of a Medicaid provider's billing begins with the selection of an audit period, which in Petitioner's case was calendar years 1997 and 1998. During that audit period, Petitioner submitted 3912 claims for Medicaid reimbursement.

21. A random sample of recipients, 31 out of a possible 315, was selected by a computerized random sample generator from the claims submitted by Petitioner during the audit period. All of the claims in the sample were reviewed by an analyst, who determined whether any overpayment existed with respect to those claims. An overpayment totaling $5,130.99 was determined for the 302 claims of the 31 recipients in the sample.

22. The amount of overpayment from the sample was extended to the population of the claims through a widely accepted statistical sampling formula. In extending the results of the 302 claims to the 3,912 claims, the total amount of overpayments was calculated as $55,647.92. The determination of that amount was made at the 95 percent confidence level, meaning that Respondent is confident that the overpayment is the amount that was calculated or more. There is a five percent probability that it might be less and a 95 percent chance that it would be more then the $55,647.92 that was calculated.

23. The process used by Respondent is in accordance with customary statistical methodology. However, the result does not take into account the fact that the audit period began January 1, 1997, whereas Nurse Kelley did not begin to practice at Southern Women's Group until October 16, 1997, and, therefore, worked there only 14 and one-half months (or approximately 60%) of the audit period.

24. Despite the stipulation of the parties that all issues other than the ARNP services had been resolved and that the amount in dispute was now approximately $51,000, no evidence was presented to indicate the exact amount remaining in dispute.

CONCLUSIONS OF LAW

25. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in this case pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

26. The burden of proof is on Respondent to establish by a preponderance of the evidence that its Final Agency Audit Report should be sustained. South Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440 (Fla. 3d DCA 1995.)

27. The statutes, rules and Medicaid Provider handbooks which were in effect during the period for which the services were provided govern the outcome of the dispute.

28. Section 409.907, Florida statutes (1997), reads in pertinent part as follows:

> 409.907 Medicaid provider agreements.--
>
> The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.
>
> (1) Each provider agreement shall require the provider to comply fully with all state and federal laws pertaining to the Medicaid program, as well as all federal, state, and local laws pertaining to licensure, if required, and the practice of any of the healing arts, and shall require the provider to provide services or goods of not less than the scope and quality it provides to the general public.
>
> (2) Each provider agreement shall be a voluntary contract between the agency and the provider, in which the provider agrees to comply with all laws and rules pertaining to

> the Medicaid program when furnishing a service or goods to a Medicaid recipient and the agency agrees to pay a sum, determined by fee schedule, payment methodology, or other manner, for the service or goods provided to the Medicaid recipient. Each provider agreement shall be effective for a stipulated period of time, shall be terminable by either party after reasonable notice, and shall be renewable by mutual agreement.

29. Section 409.913, Florida Statutes (1997), reads in pertinent part as follows:

> 409.913 Oversight of the Integrity of the Medicaid program.--
>
> The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.
>
> (1) For the purposes of this section, the term:
>
> * * *
>
> (d) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.
>
> * * *
>
> (14) The agency may seek any remedy provided by law, including, but not limited to, the remedies provided in subsections (12) and (15) and s. 812.035, if:
>
> * * *

(e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

* * *

(19) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such methods as evidence of overpayment.

(20) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments.

(21) The audit report, supported by agency work papers, showing an overpayment to a

> provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business.

30. The amount of overpayment in dispute was reduced by stipulation of the parties from $55,647.92 to approximately $51,000, although the exact figure remaining in dispute was not evident from the evidence presented.

31. Respondent proved that it used accepted auditing, analytical, and statistical methods in the determination of the overpayment to Petitioner.

32. The Respondent has established that the claims submitted by Petitioner for ARNP services were not in compliance with provisions of the Medicaid provider publications for the portion of the audit period that Nurse Kelley was practicing with Petitioner because she was not an approved Medicaid provider for the time period of October 1997 through December 1998.

33. Given that Petitioner's noncompliance was based on Nurse Kelley's not being an enrolled Medicaid provider, Respondent has not proven that it is entitled to the full amount of reimbursement of $51,000. The amount of reimbursement to

which Respondent is entitled is approximately 60% of $51,000, corresponding to the percentage of time of the audit period that Nurse Kelley was providing services.

34. Fines up to $5,000 for each violation are expressly permitted sanctions in the event overpayments are determined. Section 409.913(15)(c), Florida Statutes (1997). Moreover, the Agency is entitled to recover up to $15,000 in investigative, legal, and expert witness costs if it prevails at hearing. Section 409.913(22)(a), Florida Statutes (1997). The Agency has declined to seek fines or recoup costs from Petitioner.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law set forth herein, it is

RECOMMENDED:

That the Agency for Health Care Administration enter a final order sustaining the Final Agency Audit Report in part, recalculating the amount of overpayment as indicated and consistent with this Recommended Order, and requiring Petitioner to repay overpayments in the amount determined by the recalculation.

DONE AND ENTERED this 21st day of December, 2000, in Tallahassee, Leon County, Florida.

____
BARBARA J. STAROS
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of December, 2000.

ENDNOTE

1/ Patient records of claims of 24 of the 31 patients from the sample were introduced into evidence as Respondent's composite Exhibit 1-24. The records of the other seven patients of the sample were not introduced because they did not contain any policy violations.

COPIES FURNISHED:

Gerald D. Mills, MBA, JD
Healthcare Consultants of America, Inc.
Post Office Box 52979
Atlanta, Georgia 30355

L. William Porter, II, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308-5403

Julie Gallagher, General Counsel
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Florida 32308-5403

Sam Power, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive
Fort Knox Building Three, Suite 3231
Tallahassee, Florida 32308-5403

NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this recommended order. Any exceptions to this recommended order should be filed with the agency that will issue the final order in this case.